		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031823

Facility Name: WINDMILL NURSING PAVILION

Address: 16000 S. WABASH (Number) SOUTH HOLLAND (City) 60473 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3485403

Date of Initial License for Current Owners: 01/02/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,492	2,492	8
9	SNF/PED					9
10	ICF	43,191	1,972	360	45,523	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,191	1,972	2,852	48,015	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.70%

D. How many bed-hold days during this year were paid by Public Aid?
398 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/2/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/2/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 1,670

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	187,929	17,125	6,170	211,224		211,224		211,224			1
2	Food Purchase		202,615		202,615	(26,718)	175,897	(536)	175,361			2
3	Housekeeping	6,477	18,551		25,028		25,028		25,028			3
4	Laundry		11,689	76,070	87,759		87,759		87,759			4
5	Heat and Other Utilities			123,107	123,107		123,107	1,202	124,309			5
6	Maintenance	60,014	26,541	145,296	231,851		231,851	8,671	240,522			6
7	Other (specify):*			8,614	8,614		8,614	657	9,271			7
8	**TOTAL General Services**	254,420	276,521	359,257	890,198	(26,718)	863,480	9,994	873,474			8
	B. Health Care and Programs											
9	Medical Director			600	600		600		600			9
10	Nursing and Medical Records	1,797,828	69,232	4,600	1,871,660		1,871,660	(3,786)	1,867,874			10
10a	Therapy	31,264	24	24,287	55,575		55,575		55,575			10a
11	Activities	114,337	7,542	1,096	122,975		122,975		122,975			11
12	Social Services	33,171		1,375	34,546		34,546		34,546			12
13	Nurse Aide Training											13
14	Program Transportation			170	170		170		170			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,976,600	76,798	32,128	2,085,526		2,085,526	(3,786)	2,081,740			16
	C. General Administration											
17	Administrative	111,569		19,200	130,769		130,769	186,372	317,141			17
18	Directors Fees											18
19	Professional Services			35,080	35,080		35,080	3,272	38,352			19
20	Dues, Fees, Subscriptions & Promotions			48,852	48,852		48,852	(34,639)	14,213			20
21	Clerical & General Office Expenses	101,789	14,418	247,261	363,468		363,468	(164,724)	198,744			21
22	Employee Benefits & Payroll Taxes			371,333	371,333	26,718	398,051		398,051			22
23	Inservice Training & Education			2,881	2,881		2,881		2,881			23
24	Travel and Seminar							662	662			24
25	Other Admin. Staff Transportation			672	672		672		672			25
26	Insurance-Prop.Liab.Malpractice			138,807	138,807		138,807	3,609	142,416			26
27	Other (specify):*			2,340	2,340		2,340	21,939	24,279			27
28	**TOTAL General Administration**	213,358	14,418	866,426	1,094,202	26,718	1,120,920	16,491	1,137,411			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,444,378	367,737	1,257,811	4,069,926		4,069,926	22,699	4,092,625			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,772	
	REPAIRS & MAINTENANCE		398	
			0	6,170
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,233	
	CONTRACTED LAUNDRY SERVICES		72,837	76,070
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,068	
	ELECTRICITY		67,201	
	WATER		19,183	
	CABLE TV - LOBBY		655	
			0	123,107
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,341	
	PAINTING & DECORATING		567	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,545	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,275	
	FIRE SERVICE		0	
	CONTRACTED BUILDING MAINTENANCE		132,568	
			0	
			0	145,296
7	**OTHER**			
	SCAVENGER		8,614	
	SECURITY SERVICE		0	8,614
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	600	600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	4,600
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	8,226	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,428	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	10,633	24,287
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,096	
			0	1,096
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,375	
			0	1,375
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDMILL NURSING PAVILION **#0031823** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		170	170
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	19,200	19,200
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,248	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	29,832	
			0	35,080
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	33,573	
	EMPLOYEE WANT ADS	XIX F	4,250	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,004	
	LICENSES & PERMITS	XIX F	895	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,157	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	973	48,852
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)			
	EQUIPMENT REPAIR & MAINTENANCE		13,967	
	OUTSIDE CLERICAL SERVICES		211,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,293	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,401	
	MESSENGER SERVICE		0	
			0	247,261

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	182,877	
	UNEMPLOYMENT COMPENSATION	XIX D	13,868	
	WORKERS COMPENSATION INSURANCI	XIX D	76,545	
	HOSPITALIZATION INSURANCE	XIX D	91,899	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,144	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	371,333
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,881	2,881
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		672	672
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		138,807	138,807
27	**OTHER**			
	BAD DEBTS	VI 24	2,340	
			0	2,340

GRAND TOTAL COLUMN 3 OTHER 1,257,811

Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			57,884	57,884		57,884	109,621	167,505			30
31	Amortization of Pre-Op. & Org.							15,995	15,995			31
32	Interest			27,889	27,889		27,889	451,046	478,935			32
33	Real Estate Taxes			285,542	285,542		285,542	2,919	288,461			33
34	Rent-Facility & Grounds			791,800	791,800		791,800	(791,800)				34
35	Rent-Equipment & Vehicles			4,895	4,895		4,895	8,037	12,932			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,168,010	1,168,010		1,168,010	(204,182)	963,828			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,831	49,796	93,627		93,627	(1,660)	91,967			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		43,831	131,921	175,752		175,752	(1,660)	174,092			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,444,378	411,568	2,557,742	5,413,688		5,413,688	(183,143)	5,230,545			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(83,162)	30		9
10	Interest and Other Investment Income	(225)	32		10
11	Discounts, Allowances, Rebates & Refunds	(103)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(433)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,293)	21		18
19	Entertainment		20		19
20	Contributions	(2,157)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,340)	27		24
25	Fund Raising, Advertising and Promotional	(33,573)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (126,286)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(56,857)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (56,857)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (183,143)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(536)	0	0	0	0	0	0	0	0	0	0	(536)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,202	0	0	0	0	0	0	0	0	1,202	5
6	Maintenance	0	0	959	7,712	0	0	0	0	0	0	0	8,671	6
7	Other (specify):*	0	0	0	0	657	0	0	0	0	0	0	657	7
8	TOTAL General Services	(536)	0	2,161	7,712	657	0	0	0	0	0	0	9,994	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(3,786)	0	0	0	0	0	(3,786)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	(3,786)	0	0	0	0	0	(3,786)	16
	C. General Administration													
17	Administrative	0	0	0	186,372	0	0	0	0	0	0	0	186,372	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,272	0	0	0	0	0	0	0	0	3,272	19
20	Fees, Subscriptions & Promotions	(35,730)	0	1,091	0	0	0	0	0	0	0	0	(34,639)	20
21	Clerical & General Office Expenses	(4,293)	(211,600)	43,979	7,190	0	0	0	0	0	0	0	(164,724)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	662	0	0	0	0	0	0	0	0	662	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,609	0	0	0	0	0	0	0	0	3,609	26
27	Other (specify):*	(2,340)	0	7,519	0	16,760	0	0	0	0	0	0	21,939	27
28	TOTAL General Administration	(42,363)	(211,600)	60,132	193,562	16,760	0	0	0	0	0	0	16,491	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,899)	(211,600)	62,293	201,274	17,417	(3,786)	0	0	0	0	0	22,699	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(83,162)	188,716	4,067	0	0	0	0	0	0	0	0	109,621	30
31	Amortization of Pre-Op. & Org.	0	15,995	0	0	0	0	0	0	0	0	0	15,995	31
32	Interest	(225)	447,422	3,849	0	0	0	0	0	0	0	0	451,046	32
33	Real Estate Taxes	0	0	2,919	0	0	0	0	0	0	0	0	2,919	33
34	Rent-Facility & Grounds	0	(791,800)	0	0	0	0	0	0	0	0	0	(791,800)	34
35	Rent-Equipment & Vehicles	0	0	8,037	0	0	0	0	0	0	0	0	8,037	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(83,387)	(139,667)	18,872	0	0	0	0	0	0	0	0	(204,182)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,660)	0	0	0	0	0	(1,660)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(1,660)	0	0	0	0	0	(1,660)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(126,286)	(351,267)	81,165	201,274	17,417	(5,446)	0	0	0	0	0	(183,143)	45

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING SERVICES	$ 211,600	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (211,600)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	791,800	16000 S. WABASH PARTNERSHIP			(791,800)	7
8	V	30	DEPRECIATION		" "		188,716	188,716	8
9	V	31	AMORTIZATION		" "		15,995	15,995	9
10	V	32	INTEREST		" "		447,422	447,422	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,003,400			$ 652,133	$ * (351,267)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,202	$ 1,202	15
16	V	6	REPAIR & MAINT.		" " "	100.00%	959	959	16
17	V	7	EMP. BEN. - GEN, SERVICES		" " "	100.00%			17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	3,272	3,272	18
19	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	1,091	1,091	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	43,979	43,979	20
21	V	24	SEMINARS AND TRAVEL		" " "	100.00%	662	662	21
22	V	26	INSURANCE		" " "	100.00%	3,609	3,609	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "	100.00%	7,519	7,519	23
24	V	30	DEPRECIATION		" " "	100.00%	4,067	4,067	24
25	V	32	INTEREST		" " "	100.00%	3,849	3,849	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	2,919	2,919	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	8,037	8,037	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 81,165	$ * 81,165	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 7,712	$ 7,712	15
16	V	10	NURSING CMP. - SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	42,874	42,874	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	63,106	63,106	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%	33,976	33,976	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	11,851	11,851	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	14,784	14,784	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	19,781	19,781	27
28	V	21	CLERICAL. CMP. - S. AARON		" " "	100.00%	7,190	7,190	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 201,274	$ * 201,274	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 657	$ 657	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V	27	EMP.BEN. - M. MAUER		" " "	100.00%	1,360	1,360	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	2,100	2,100	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%	5,701	5,701	19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	1,041	1,041	22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	2,138	2,138	25
26	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	3,004	3,004	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	1,416	1,416	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 17,417	$ * 17,417	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 13,658	DYNAMIC REHAB CONSULTANTS LLC	100.00%	$ 13,658	$	15
16	V	19	PROFESSIONAL FEES		" " "	100.00%			16
17	V	22	EMPLOYEE BENEFITS		" " "	100.00%			17
18	V	39	ANCILLARY SERVICES	39,365	" " "	100.00%	39,365		18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	14,998	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	11,212	(3,786)	21
22	V	39	ANCILLARY EXPENSE	6,576	" " "	100.00%	4,916	(1,660)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,597			$ 69,151	$ * (5,446)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 42,874	17-7	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	63,106	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	33,976	17-7	3
4	" "							MGMT FEE	19,200	17-3	4
5	SHARON AARON		CLERICAL					SALARY	7,190	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 166,346		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	423,801	12	$ 10,611	$	48,015	$ 1,202	1
2	6	REPAIR & MAINT.	" "	423,801	12	8,462		48,015	959	2
3	7	EMP. BEN. - GEN, SERVICES	" "	423,801	12			48,015	0	3
4	19	PROFESSIONAL FEES	" "	423,801	12	28,879		48,015	3,272	4
5	20	DUES AND SUBSCRIPTION	" "	423,801	12	9,628		48,015	1,091	5
6	21	CLERICAL & GENERAL	" "	423,801	12	388,179	279,093	48,015	43,979	6
7	24	SEMINARS AND TRAVEL	" "	423,801	12	5,844		48,015	662	7
8	26	INSURANCE	" "	423,801	12	31,856		48,015	3,609	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	423,801	12	66,362		48,015	7,519	9
10	30	DEPRECIATION	" "	423,801	12	35,898		48,015	4,067	10
11	32	INTEREST	" "	423,801	12	33,975		48,015	3,849	11
12	33	REAL ESTATE TAXES	" "	423,801	12	25,761		48,015	2,919	12
13	35	EQUIPMENT RENTAL	" "	423,801	12	70,935		48,015	8,037	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 716,390	$ 279,093		$ 81,165	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 59,901	$ 59,901	5	$ 7,712	1
2	10	NURSING CMP. - SUE G.	" "							2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	373,726	373,726	5	42,874	3
4	17	ADMIN. CMP. - M. AARON	" "	40	9	490,141	490,141	5	63,106	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,118	191,118	8	33,976	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	40	3	49,500	49,500			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	7	69,097	69,097			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	77,417	77,417	7	11,851	8
9	17	ADMIN. CMP. - E. CASSON	" "							9
10	17	ADMIN. CMP. - S. BOGEN	" "	11	2	40,545	40,545			10
11	17	ADMIN. CMP. - S. LEVY	" "	45	11	128,818	128,818	5	14,784	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	9	153,735	153,735	6	19,781	13
14	21	CLERICAL. CMP. - S. AARON	" "	40	11	62,676	62,676	5	7,190	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,708,674	$ 1,708,674		$ 201,274	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 5,106	$	5	$ 657	1
2	15	EMP. BEN. - SUE G.	" "							2
3	27	EMP.BEN. - M. MAUER	" "	40	11	11,858		5	1,360	3
4	27	EMP. BEN. - M. AARON	" "	40	9	16,312		5	2,100	4
5	27	EMP. BEN. - F. AARON	" "	45	6	32,071		8	5,701	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	40	3	26,160				6
7	27	EMP. BEN. - S. KOPLIN	" "	40	7	26,142				7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	9	6,801		7	1,041	8
9	27	EMP. BEN. - E. CASSON	" "							9
10	27	EMP. BEN. - S. BOGEN	" "	11	2	3,320				10
11	27	EMP. BEN. - S. LEVY	" "	45	11	18,630		5	2,138	11
12	27	EMP. BEN. - H. ALTER	" "	40	1	4,292				12
13	27	EMP. BEN. - NON-OWNER	" "	45	9	23,348		6	3,004	13
14	27	EMP. BEN. - S. AARON	" "	40	11	12,346		5	1,416	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 186,386	$		$ 17,417	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						13,658	2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "						39,365	5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						11,212	9
10	39	ANCILLARY EXPENSE	" "						4,916	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 69,151	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	AMERICAN NATIONAL BANK		X	MORTGAGE	$55,899.00	10/00	$ 5,625,000	$ 4,980,017		8.6500	$ 447,422	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	DEMAND			106,319		PRIME+	24,431	6
7			X	INSURANCE FINANCING							3,458	7
8												8
9	TOTAL Facility Related				$55,899.00		$ 5,625,000	$ 5,086,336			$ 475,311	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,625,000	$ 5,086,336			$ 475,311	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	278,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	277,542	2
3. Under or (over) accrual (line 2 minus line 1).	$	(458)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	286,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	285,542	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	232,380	8
	1999	237,206	9
	2000	244,044	10
	2001	269,495	11
	2002	277,542	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDMILL NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031823

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-15-302-051-0000	NURSING HOME	$ 277,541.70	$ 277,541.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 277,541.70	$ 277,541.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 354,221	1
2					2
3	TOTALS			$ 354,221	3

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1986	1976	$ 3,187,988	$ 188,716	30	$ 106,266	$ (82,450)	$ 1,700,256	4
5											5
6											6
7											7
8					50,258	1,289	35	1,436	147	14,838	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1989	6,334	201	31.5	201		2,906	9
10	LEASEHOLD IMPROVEMENT			1990	1,538	49	20	77	28	807	10
11	LEASEHOLD IMPROVEMENT			1991	26,695	847	20	1,335	488	13,522	11
12	LEASEHOLD IMPROVEMENT			1992	4,785	152	20	239	87	2,270	12
13	LEASEHOLD IMPROVEMENT			1993	8,024	255	31.5	255		2,745	13
14	LEASEHOLD IMPROVEMENT			1993	36,822	944	39	944		9,781	14
15	LEASEHOLD IMPROVEMENT			1994	38,826	996	39	996		9,157	15
16	LEASEHOLD IMPROVEMENT			1995	21,539	553	39	553		4,790	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR			1996	1,604	41	39	41		320	17
18	ROOF REPAIR			1996	3,800	97	39	97		724	18
19	GAZEBO			1996	1,282	33	39	33		243	19
20	ASPHALT REMOVE & REPLACE			1996	2,686	69	39	69		504	20
21	ROOF REPAIR			1996	7,000	179	39	179		1,305	21
22	HOT WATER TANK			1996	12,098	310	39	310		2,209	22
23	CABINETS, SINK, COUNTERTOP, SHELVES			1997	6,844	175	39	175		1,101	23
24	REHAB ROOM, FLOORING,HAND RAILS			1997	105,092	2,695	39	2,695		17,026	24
25	ROOFING			1997	45,500	1,167	39	1,167		7,343	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS			1997	4,721	121	39	121		761	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS			1997	26,497	679	39	679		4,272	27
28	FIRE ALARM REPAIR, DOOR ALARM			1998	3,359	86	39	86		467	28
29	DRAPES & INSTALLATION			1998	5,965	153	39	153		820	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS			1998	14,240	365	39	365		1,959	30
31	EXHAUST FAN & INSTALLATION			1998	2,285	59	39	59		307	31
32	ROOF REPAIR			1998	8,750	224	39	224		1,206	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS			1998	22,500	577	39	577		3,117	33
34	ELECTRICAL WORK			1998	5,376	138	39	138		739	34
35	COUNTER TOPS			1998	712	18	39	18		96	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING LOT IMPROVEMENT	1998	$ 1,185	$ 30	39	$ 30	$	$ 150	37
38	NURSES STATION	1999	16,601	426	39	426		2,113	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		508	39
40	FIRE SYSTEM	1999	2,625	67	39	67		331	40
41	FLOOR TILE	1999	10,807	277	39	277		1,374	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		1,162	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		1,019	43
44	AIR CONDITIONING	1999	14,451	371	39	371		1,742	44
45	RAILINGS	1999	3,282	84	39	84		389	45
46	ROOF WORK	1999	4,500	115	39	115		494	46
47	NURSE STATION	2000	7,090	258	27.5	258		915	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		823	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		1,085	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		333	50
51	SMOKE DETECTOR	2000	3,472	126	27.5	126		446	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	1,045	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		490	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		501	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		249	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		497	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		206	57
58	CONCRETE PAD	2002	1,662	110	15	110		165	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		35	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		153	60
61	ROOF REPAIRS	2002	5,550	201	27.5	201		277	61
62	WALL AIR CONDITIONER	2003	2,277	38	27.5	38		38	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	35	27.5	35		35	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	136	27.5	136		136	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,820,406	$ 205,892		$ 124,382	$ (81,510)	$ 1,822,302	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 321,865	$ 36,893	$ 38,301	$ 1,408	10	$ 214,730	71
72	Current Year Purchases	11,473	5,103	574	(4,529)	10	574	72
73	Fully Depreciated Assets	224,010					242,261	73
74	RELATED PARTY	30,834	1,699	2,422	723	10	21,014	74
75	TOTALS	$ 588,182	$ 43,695	$ 41,297	$ (2,398)		$ 478,579	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			$ 6,378	$ 1,080	$ 1,826	$ 746		$ 6,251	76
77										77
78										78
79										79
80	TOTALS			$ 6,378	$ 1,080	$ 1,826	$ 746		$ 6,251	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,769,187	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 250,667	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,505	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (83,162)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,307,132	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,895 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WINDMILL NURSING PAVILION

STATE OF ILLINOIS
0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 10,059	$		$ 10,059	1
2	Licensed Speech and Language Development Therapist		hrs			7,449			7,449	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			29,463			29,463	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				35,628		35,628	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,LAB,RADIOLOGY Other (specify):					2,825	8,203		11,028	13
14	TOTAL			$		$ 49,796	$ 43,831		$ 93,627	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 54,338	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	910,155		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,884		6
7	Other Prepaid Expenses	3,330		7
8	Accounts Receivable (owners or related parties)	65,124		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,086,831	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	582,160		15
16	Equipment, at Historical Cost	611,234		16
17	Accumulated Depreciation (book methods)	(639,143)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 554,251	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,641,082	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 285,581	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	600,000		29
30	Accrued Salaries Payable	214,326		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,641		31
32	Accrued Real Estate Taxes(Sch.IX-B)	286,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,393,548	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,393,548	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 247,534	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,641,082	$	48

***(See instructions.)**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 219,042	1
2	Restatements (describe):		2
3		(52,681)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 166,361	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(284,827)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ADDITIONAL PAID IN CAPITAL	366,000	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 81,173	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 247,534	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,088,317	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,088,317	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	30,485	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 30,485	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	225	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 225	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	9,731	27
28	DISCOUNTS EARNED	103	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,834	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,128,861	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	890,198	31
32	Health Care	2,085,526	32
33	General Administration	1,094,202	33
	B. Capital Expense		
34	Ownership	1,168,010	34
	C. Ancillary Expense		
35	Special Cost Centers	93,627	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,413,688	40
41	**Income before Income Taxes (line 30 minus line 40)****	(284,827)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (284,827)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,949	2,186	$ 72,978	$ 33.38	1
2	Assistant Director of Nursing	2,863	3,200	68,826	21.51	2
3	Registered Nurses	2,245	2,379	46,522	19.56	3
4	Licensed Practical Nurses	37,566	41,216	774,735	18.80	4
5	Nurse Aides & Orderlies	82,746	88,184	814,997	9.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,167	1,305	31,264	23.96	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,893	1,966	22,599	11.49	9
10	Activity Assistants	10,544	11,585	91,738	7.92	10
11	Social Service Workers	1,928	2,100	33,171	15.80	11
12	Dietician					12
13	Food Service Supervisor	1,957	2,182	32,927	15.09	13
14	Head Cook	3,207	3,439	33,368	9.70	14
15	Cook Helpers/Assistants	14,231	15,331	121,634	7.93	15
16	Dishwashers					16
17	Maintenance Workers	4,008	4,461	60,014	13.45	17
18	Housekeepers	973	966	6,477	6.70	18
19	Laundry					19
20	Administrator	1,842	2,115	65,852	31.14	20
21	Assistant Administrator	2,185	2,462	45,717	18.57	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,979	7,775	101,789	13.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,925	2,057	19,770	9.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,208	194,909	$ 2,444,378 *	$ 12.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	267	$ 5,772	1-3	35
36	Medical Director	12	600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	115	4,600	10-3	39
40	Physical Therapy Consultant	235	8,226	10a-3	40
41	Occupational Therapy Consultant	155	5,428	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	196	10,633	10a-3	43
44	Activity Consultant	24	1,096	11-3	44
45	Social Service Consultant	25	1,375	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,028	$ 37,730		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNMARIE HARRINGTON	ADMIN	0	$ 65,852
JOYCE MCGEE	ASST ADMIN	0	45,717
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 111,569

B. Administrative - Other

Description	Amount
FRED AARON - MANAGEMENT FEE	$ 19,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 19,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR	ACCOUNTING	$ 14,946
FROST RUTTENBERG	ACCOUNTING	3,165
SACHNOFF WEAVER	LEGAL	3,281
SIDNEY BERGER	LEGAL	128
FINKEL MARTWICK	LEGAL	3,097
PERSONNEL PLANNERS	UC CONSULTANT	1,665
ECONOCARE	PURCHASING CONSLT	2,700
DART CHART SYS	MEDICARE CONSLT	1,200
HEALTH DATA	DATA PROCESSING	4,898
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 35,080

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,545
Unemployment Compensation Insurance	13,868
FICA Taxes	182,877
Employee Health Insurance	91,899
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	6,144
	0
	0
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,250
Health Care Worker Background Check	973
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	33,573
TRUST/FRANCHISE/CONTRIB/ETC	2,157
LICENSES & PERMITS	895
DUES & SUBSCRIPTIONS	7,004
MGMT CO ALLOCATION	1,091
TRUST/FRANCHISE/CONTRIB/ETC	(2,157)
Less: Public Relations Expense	(0)
Non-allowable advertising	(33,573)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,213

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
RELATED PARTY	662
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 662

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $8579**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **790** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees